

**Kentucky Board of Respiratory Care**  
**2365 Harrodsburg Rd., B350**  
**Lexington, KY 40504-3386**  
(859) 246-2747 (859) 246-2750

http://kbrc.gov

**APPLICATION FOR CONTINUING EDUCATION APPROVAL**

There is no need to complete this form if the offering has prior approval from the American Association of Respiratory Care (AARC). **(A non-refundable fee of \$10 per PROVIDER (not licensee), shall be charged for each continual education offering, good for two (2) years.)** Individual non-providers will not be charged. If insufficient information is received, your material may be returned for further documentation. For complete details of continuing education requirements consult 201 KAR 29:050

**General Information**

Pre-Approval \_\_\_\_ Post-Approval \_\_\_\_

Submitted by \_\_\_\_\_ M \_\_\_\_ F \_\_\_\_ Telephone no. (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Provider or Sponsor Number (If already given) \_\_\_\_\_

Mailing Address \_\_\_\_\_

Program Format Lecture \_\_\_\_ Video \_\_\_\_ Correspondence \_\_\_\_ Online \_\_\_\_ Other \_\_\_\_

Program Title \_\_\_\_\_

Sponsoring Organization \_\_\_\_\_

Program Location(s) \_\_\_\_\_

Program Date(s) Begin \_\_\_\_\_ End \_\_\_\_\_

Will this program be repeated? No \_\_\_\_ Yes \_\_\_\_ (Additional dates) \_\_\_\_\_

Start time \_\_\_\_\_ Stop time \_\_\_\_\_

Total Length \_\_\_\_\_ Total CEUs requested (60 min/1CEU) \_\_\_\_\_

*(A continuing education offering shall be approved in increments of no less than 30 minutes.)*

**Supporting Documentation** (Attach to application)

\_\_\_\_ Program Objectives and agenda outline

\_\_\_\_ Program Brochure

\_\_\_\_ Speaker credentials

\_\_\_\_ Pre/Post Test (if applicable)

\_\_\_\_ Course description required for all college level courses. Course must be 300 level or above.

Signature of Sponsor \_\_\_\_\_

Date \_\_\_\_\_

Acknowledging that course # with the CEU certificate or card will be issued to participant (s).

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**Do not write below this line, for Board use only.**

DATE SUBMITTED \_\_\_\_\_

DATE APPROVED \_\_\_\_\_

DENIED \_\_\_\_\_

CEU HOURS GIVEN \_\_\_\_\_

PROVIDER # \_\_\_\_\_

COURSE # \_\_\_\_\_

**PAYMENT**

Check # \_\_\_\_\_

Check amt. \_\_\_\_\_

Money Order \_\_\_\_\_

Credit Card \_\_\_\_\_ (Contact KBRC to complete.)

*(Do not write credit card info on form.)*